7.02: continued

Medicaid Program. The medical assistance program administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E and in accordance with Title XIX of the Federal Social Security Act.

Medical Assistance Program. The Medicaid program, the Veterans Administration health and hospital programs and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

Medical Hardship. A situation in which major expenditures for health care and/or income loss stemming from an individual's medical condition have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that he or she will be unable to pay for needed medical services, as described in a hospital's credit and collection policy.

Medical Service Corporation. A corporation established for the purpose of operating a nonprofit medical service plan as provided in M.G.L. c. 176B.

Medically Necessary Service. A service that is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endangers life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include:

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and
(g) the provision of whole blood; provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

Medicare Program. The medical insurance program established by Title XVIII of the Federal Social Security Act.

Provider. Any person, corporation, partnership, governmental unit, state institution and other entity qualified under the laws of the commonwealth to perform or provide health care services.

Private Sector Charges. Gross patient revenues based on all charges to purchasers and third party payers, including charges under M.G.L. c. 152, exclusive of charges for services to publicly aided patients, charges under Titles XVIII and XIX of the Federal Social Security Act, free care, reduced by all income, recoveries and adjustments, and bad debt, reduced by all income, recoveries and adjustments.

Publicly Aided Patient. A person who receives hospital care and services for which a governmental unit is liable in whole or in part under a statutory program of public assistance.

Purchaser. A natural person responsible for payment for health care services rendered by a hospital.

Self-Insurance Health Plan. A plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and administrative costs.

Shortfall Amount. The amount equal to the difference between the total allowable free care costs for all hospitals and the revenue available for reimbursement of free care to the hospitals.

7.02: continued

Total Patient Care Costs. Patient care cost as reported by the hospital pursuant to the instructions of the Division.

Uninsured Patient. A patient who is not covered by any of the following:

(a) a health insurance plan including the medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization; or

(b) a self insurance health plan including a plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan and the administrative costs; or

(c) a medical assistance program including the medicaid program, the Veterans Administration health and hospital program and any other assistance program operated by a governmental unit for persons categorically eligible for such program.

A patient shall not be deemed uninsured if such patient has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures.

7.03: Reporting Requirements

(1) Required Reports and Filing Dates. Each acute care hospital shall comply with the following reporting requirements:

(a) DHCFP Form UC-97 or any successor form, due no later than 45 days after the last day of the fiscal month for which the report is being submitted;

(b) Its manual or any document, in whatever form, setting forth the hospital's classification of persons presenting for unscheduled treatment, the urgency of treatment associated with each such classification, the location or locations at which such patients might present themselves and any other relevant and necessary instruction to hospital personnel who routinely see patients presenting for unscheduled treatment regarding said classification system. The manual or document must list those classifications which qualify as emergency care under 114.6 CMR 7.00. Such manual or document must be filed with the Division by May 15, 1992. Any subsequent amendments thereto shall be filed with the Division at least 60 days prior to the effective date of the amendment. Such manual or document must be accepted for filing by the Division before it is relied upon by the hospital in claiming any payment from the pool for emergency care;

(c) Its credit and collection policy, as defined by 114.6 CMR 7.02. The policy which has been filed pursuant to 114.6 CMR 2.03 shall satisfy the requirements of 114.6 CMR 7.00. Any subsequent amendments thereto shall be filed with the Division at least 60 days prior to the effective date of the amendment;

(d) Each acute care hospital shall file in the UB-92 format, information regarding its free care write-offs. Each acute care hospital shall report the utilization information on the number of inpatient admissions and make a good faith effort to report such information for outpatient visits by the following categories:

1. date of birth;
2. income by reporting the following applicable free care category;
   a. exempt;
   b. exempt in part; or
   c. medical hardship;
3. primary diagnosis and up to six co-existing secondary diagnoses by ICD-9 for inpatient admissions and for outpatient visits;
4. charges for services rendered;
5. billing number;
6. medical record number (optional); and
7. date of admission and/or date of discharge if inpatient and date of service if outpatient.

7.03: continued

In addition, each acute care hospital shall file in the UB-92 format, information regarding its uncollected costs for emergency care to uninsured patients. Each acute care hospital shall make a good faith effort to report the utilization information on the number of inpatient admissions and outpatient visits by the following categories:

1. date of birth;
2. family income by the following categories:
   a. equal to or less than 200% of the Federal Poverty Income Guidelines;
   b. income between 200% and 400% of the Federal Poverty Income Guidelines; or
   c. income above 400% of the Federal Poverty Income Guidelines.
3. primary diagnosis and up to six co-existing secondary diagnoses by ICD-9 for inpatient admissions and for outpatient visits;
4. charges for services rendered;
5. billing number;
6. medical record number (optional); and
7. date of admission and/or date of discharge if inpatient and date of service if outpatient.

Each acute hospital shall, upon request, provide the Division or its agent with access to patient account records and related reports.

(e) Each acute hospital shall file or make available information which is required by 114.6 CMR 7.03 or which the Division deems reasonably necessary for implementation of 114.6 CMR 7.00 in accordance with time limits set forth in 114.6 CMR 7.03, or within 15 days from the date of request from the Division, unless a different time is specified in the request. The Division may, for cause, extend the filing date for the submission of reports, schedules, reporting forms, budgets, information, books and records. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(2) Enforcement of Reporting Requirements. If a hospital fails to meet the reporting requirements of 114.6 CMR 7.03(1), the Division may determine that the hospital does not incur any free care expenses for the period for which it fails to meet the reporting requirements. If the Division makes such a determination it will adjust the hospital's liability to or from the uncompensated care pool as calculated pursuant to 114.6 CMR 7.04 to reflect this determination.

7.04: Payments To and From the Uncompensated Care Pool

Each acute hospital shall make payments to or receive payments from the uncompensated care pool in accordance with 114.6 CMR 7.04.

(1) Payments to the Division or its agent shall be made in accordance with instructions from the Division.

(2) If any part of the hospital's payment is not made on the due date, the Division shall assess a 5% surcharge on the amount that is overdue. The Division shall reduce this surcharge to 1% of the amount that is overdue if the hospital satisfies and documents the following conditions:

(a) The hospital has applied for and been denied a sufficient working capital loan by a qualified lending institution within the past 90 days; and

(b) The amount overdue exceeds 2% of the hospital's average monthly revenues for the prior six months. The hospital must apply for such surcharge reduction within 15 days of receiving the initial assessment of the surcharge, and must document the above conditions within 60 days of receiving the initial assessment of this surcharge.

(3) Revenue Available for Payments to Hospitals for Free Care.

(a) The revenue available shall consist of revenues produced by hospital assessments under 114.6 CMR 7.04, state appropriations of federal financial participation funds, any other appropriations, and any supplemental funding, less reserves, payments to community health centers under 114.6 CMR 8.04, and uncompensated care pool expenses for activities authorized in M.G.L. c. 118G, § 18.

(b) For FY 1997, supplemental funding shall consist of $15,000,000 transferred from Compliance Liability revenue.

7.04: continued

(c) Supplemental funding shall be the primary source of funding for free care to community health centers. If this funding source is insufficient, then revenue provided through other sources will be made available. Any supplemental funding remaining after payments to community health centers will be made available for other purposes of the pool.

(4) Gross Payments to or from the Uncompensated Care Pool. Each hospital's payments to and from the uncompensated care pool shall be based on gross liability to and from the uncompensated care pool. The Division will determine the gross liability of a hospital to or from the uncompensated care pool as follows:

(a) The hospital shall make payments of its gross liability to the uncompensated care pool in accordance with the invoices from the Division. The Division shall make the appropriate gross payment from the uncompensated care pool to the hospital.

(b) The hospital's fiscal year gross liability to the uncompensated care pool shall be calculated as follows:

1. for the time period of October 1, 1991 to September 30, 1992, inclusive, it will be as set forth in St. 1991, c. 495, § 54;
2. for the time period beginning on October 1, 1992, it will equal the product of:
   a. the ratio of its private sector charges to all hospitals' private sector charges; and
   b. the private sector liability to the uncompensated care pool as determined by the general court.

(c) The uncompensated care pool's gross liability to the hospital shall be determined as follows:

1. pool's gross liability to each hospital shall be equal to the total allowable free care costs of the hospital less the pool shortfall allocation;
2. the total allowable free care costs shall be the product of the cost-to-charge ratio and the total free care charges less free care income, related bad debt recoveries and audit results. Gross free care charges shall not include any sums attributable to free care for which reimbursement is available from other sources including, but not limited to, the Medicare program, foreign health insurance coverage, and a motor vehicle liability policy irrespective of whether such reimbursement has been collected by a hospital. Unpaid Medicare charges, unpaid charges covered by either a foreign health insurance policy or through a foreign governmental health program, and unpaid charges covered by a motor vehicle liability policy shall be considered reimbursable by the pool to the extent allowed under 114.6 CMR 7.02: Free Care.
3. the pool shortfall allocation shall be the lesser of the product of the ratio of the hospital's total patient care costs to the total patient care costs of all hospitals, multiplied by the shortfall amount or the amount equal to the total allowable free care costs of the hospital.

(d) If a hospital is unable to determine the appropriate segregation of bad debt related to emergency care from the bad debt related to non emergency care for any fiscal year, then the Division shall make an appropriate estimate. If a hospital is unable to determine recoveries, the Division shall estimate the amount of recoveries of bad debt which is attributable to bad debt arising from the emergency care to uninsured patients on the basis of the ratio of the total of the bad debt recoveries to the total of the bad debt.

(5) Interim Calculation of a Hospital's Payment to or from the Uncompensated Care Pool. In order to facilitate timely payments to and from the uncompensated care pool, the Division will from time to time calculate each hospital's payment to and from the uncompensated care pool for a fiscal year by estimating its liability to and from the uncompensated care pool and crediting any payments made to and from the uncompensated care pool for the fiscal year in question. The calculation shall be made according to the following guidelines:

(a) The Division shall notify each hospital of the methodology used to calculate payments and the results of the calculation for the hospital;

(b) If a hospital has not reported data required to calculate the hospital's net payment, the Division may substitute for the required data elements relevant industry averages, prior year reports by the hospital, or other data the Division deems appropriate;

(c) The Division shall adjust payments to reflect the availability of funds, as well as any special payments made under 114.6 CMR 7.04(10);

7.04: continued

(d) The Division may adjust payments to reflect uncompensated care pool expenses for activities authorized in M.G.L. c. 118G.

(6) Final Calculation of a Hospital's Payment to and from the Uncompensated Care Pool. The final settlement between the uncompensated care pool and a hospital for a fiscal year shall comply with the guidelines set forth in 114.6 CMR 7.04(5) and it shall be as follows:

(a) It shall take place upon completion of the relevant audit and calculations by the Division, for that fiscal year;

(b) It shall be determined using actual private sector charges, final cost-to-charge ratios, and actual free care charges, each having been adjusted for any audit findings;

(c) It shall include reconciliation of any interim payments and estimated liabilities to and from the uncompensated care pool.

(7) Special Calculation for the Settlement Between the Hospitals and the Pool for the Fiscal Year of October 1, 1991 to September 30, 1992. In order to facilitate timely settlement of payments to and from the pool and to promote fair distribution of pool funds among the participating hospitals, the Division will, for the time period of October 1, 1991 to September 30, 1992, determine the gross free care charges eligible for reimbursement before adjustment as follows:

(a) For the time period of October 1, 1991 to March 31, 1992, for those hospitals which are not able to determine the amount of bad debt arising from emergency care to the uninsured, the estimate of the amount of the free care charges eligible for reimbursement before adjustment shall be calculated pursuant to the following rules and formulas:

1. the time period of October 1, 1991 to March 31, 1992 shall be designated as "P1";
2. the time period of April 1, 1992 to September 30, 1992 shall be designated as "P2";
3. the free care charges as reported on the form UC-92 (less all income, recoveries and adjustments attributable thereto) shall be designated as "FC";
4. the free care charges as reported on the form UC-92 which are attributable to bad debt arising from emergency care to uninsured patients shall be designated as "EBD";
5. the total bad debt charges as reported on the form UC-92 shall be designated as "BD";
6. the uncompensated care for any period shall be the sum of FC for such time period and BD (less all income, recoveries and adjustments attributable thereto) for such time period and shall be designated as "UC";
7. The ratio of EBDP2 to the sum of FCP2 and BDP2 shall be multiplied by UCP1. This product will be the gross free care charges which are eligible for reimbursement.

(b) For the time period of April 1, 1992 to September 30, 1992 for all hospitals and for the time period October 1, 1991 to March 31, 1992, if such reporting is refiled, for hospitals which are able to specifically segregate bad debt arising from emergency care to the uninsured for the time period October 1, 1991 to March 31, 1992, the free care charges as reported on form UC-92 less all income, recoveries and adjustments attributable thereto, shall be the gross free care charges which are eligible for reimbursement.

(8) Reimbursement of Physicians for the Cost of Free Care. Any hospital which has the status of a disproportionate share hospital pursuant to 114.1 CMR 36.08 and which receives payments from the uncompensated care pool, and such payments are based upon a calculation of the cost-to-charge ratio which includes, provides for, or has an allowance, calculated by the Commission, for the cost of free care provided by physicians at such hospital, shall use that portion of the uncompensated care pool payments which is attributable to such cost to reimburse such physicians for such free care.

(9) Updates and Final Settlements. The Division may calculate all updates and make final settlements with hospitals on a net basis. The net shall be the hospital's gross liability to the uncompensated care pool, as determined pursuant 114.6 CMR 7.04(4)(b), minus the uncompensated care pool's gross liability to the hospital, as determined pursuant to 114.6 CMR 7.04(4)(c). If the difference is positive, then that amount shall be the hospital's net liability to the uncompensated care pool; if the difference is negative, then that amount shall be the net liability of the uncompensated care pool to the hospital.

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7.04: continued

(10) Special Payment. Beginning in FY 1997, the Uncompensated Care Pool will make a one-time payment to hospitals as early in the fiscal year as is administratively feasible. The total amount of this payment to all hospitals will equal the amount of supplemental funding available, less any amount transferred pursuant to 114.6 CMR 7.04(11). This payment will be allocated in accordance with 114.6 CMR 7.04(4), using the preliminary cost to charge ratio. The Division may offset any funds distributed under this section by any amounts owed by hospitals for current or prior years' unpaid liabilities. These payments will be included in final settlements calculated pursuant to 114.6 CMR 7.04(6).

(11) Specialty Hospital Exemption. For the Commonwealth's FY 1997 any specialty hospital that provides free care and whose gross outpatient service revenue equals at least 80% of its gross patient service revenue as of January 1, 1996, shall be exempt from the provisions of 114.6 CMR 7.04. The Division will determine the amount owed for state FY 1997 by said specialty hospital. The Division will transfer from Compliance Liability revenues into the Uncompensated Care Pool an amount equal to the amount owed by said specialty hospital for state FY 1997.

7.05: Administrative Review and Adjudicatory Proceeding

(1) Administrative Review. A hospital aggrieved by any action or failure to act by the Division may file an appeal pursuant to the provisions of M.G.L. c. 118G or it may seek a review pursuant to the provisions of 114.6 CMR 7.05.

(2) Administrative Review by the Division. Within 21 days after receiving notice of the Division's determination of a hospital's net payment to or from the pool pursuant to 114.6 CMR 7.04(6), the hospital may request administrative review of the determination. The scope of this administrative review is to consider whether the Division's determination contains any technical errors in the calculation itself or in the data used for the calculation. This administrative review will not consider issues relating to the validity of 114.6 CMR 7.05 or the methodology contained in the regulations for determining a hospital's net payment to or from the pool. Such issues may be raised in a request for judicial review filed pursuant to M.G.L. c. 30A, § 7.

(a) Request for Administrative Review. The hospital's request for administrative review must be submitted in writing to the Commissioner of the Division. The request must describe the technical errors and any necessary corrective actions. If a hospital's request for administrative review does not contain the required information and materials, the Commissioner shall notify the hospital, in writing, that the hospital has ten days from the date of the notice to supply the missing information or materials. If the hospital fails to supply the missing information or materials identified by the Commissioner, the Commissioner shall deny the hospital's request for administrative review.

(b) Administrative Review Process and Decision. Upon receipt of request for administrative review containing the required information, the Commissioner shall refer the matter to a designated employee of the Division for review and decision. The designated employee will review the information and materials supplied by the hospital and may meet or otherwise hold discussions with hospital representatives to clarify certain information. After completing this review, the designated employee will issue a written decision on the hospital's request. The decision will state whether or not any adjustment to the Division's determination of net payment to or from the pool will be made and will give a brief explanation of the reasons for this decision. When such a decision is issued with respect to a calculation made after a hospital's fiscal year has ended and using the hospital's actual audited data for that fiscal year, the decision shall constitute a Notice of Agency Action and shall contain the notice and other information related to adjudicatory proceedings set forth in 801 CMR 1.02(6).

7.05: continued

(3) Adjudicatory Proceedings.

(a) Submission of Claim for Adjudicatory Proceeding. Within 21 days of receiving a Notice of Agency Action described in 114.6 CMR 7.05(2)(b), the hospital may submit to the Commissioner of the Division a Claim for Adjudicatory Proceeding to resolve any legal and factual issues raised during any administrative review(s) for that fiscal year. A Claim for Adjudicatory Proceeding must be submitted in writing, must identify the issues of law and fact in dispute between the hospital and the Division, and must describe the evidence presented during administrative review to support the hospital's position. A Claim for Adjudicatory Proceeding cannot raise issues of law or fact and cannot cite evidence that was not considered during administrative review.

(b) Disposition of Claim for Adjudicatory Proceeding. The Commissioner or the Commissioner's designee shall review a Claim for Adjudicatory Proceeding together with the related administrative review decision(s) and any materials in the Division's files related to those administrative review decision(s). If the Commissioner or the designee determines, after the review, that there are no genuine issues of material fact and no issues of law in dispute between the hospital and the Division, the Commissioner shall issue an order dismissing the Claim for Adjudicatory Proceeding, and this order shall constitute a final decision of the Division subject to judicial review under M.G.L. c. 30A, § 14. If the Commissioner or the designee determines, after this review, that there are genuine issues of material fact in dispute between the hospital and the Division, the Commissioner shall issue an order referring the matter to an independent hearing officer designated by the Commissioner to conduct an adjudicatory proceeding in accordance with 801 CMR 1.02 *et seq.* If the Commissioner or the designee determines, after this review, that only legal issues are in dispute between the hospital and the Division, the Commissioner or the designee may issue an order referring the issues to an independent hearing officer designated by the Commissioner to conduct adjudicatory proceedings pursuant to 801 CMR 1.02 *et seq.*, or the Commissioner or the designee may decide the issues after giving both the hospital and the Division reasonable notice and an opportunity to be heard on these issues. A decision on legal issues by the Commissioner or the designee shall constitute a final decision of the Division subject to judicial review under M.G.L. c. 30A, § 14.

(c) Conduct of Adjudicatory Proceeding. An adjudicatory proceeding referred to an independent hearing officer designated by the Commissioner shall be governed by 801 CMR 1.02 and 1.03. Such a proceeding also will be governed by the following rules and procedures:

1. An adjudicatory proceeding will address only those issues identified in the Commissioner's order referring the matter to an independent hearing officer.
2. The hearing officer will only consider evidence that was presented to the Division during administrative review, except in those extraordinary circumstances where the hospital can demonstrate that the evidence could not have been obtained or produced at the time of the administrative review.
3. Upon conclusion of the adjudicatory proceeding, the hearing officer will prepare and forward to the Commissioner or his designee a written, recommended decision of the Division. The recommended decision will address each of the issues cited in the Commissioner's order referring the matter to the hearing officer. The Commissioner or the Commissioner's designee may adopt, modify or order reconsideration of the hearing officer's recommended decision.
4. The Commissioner will issue the final decision of the Division subject to judicial review under M.G.L. c. 30A, § 14.

7.06: Criteria for Acquisition and Verification of Financial Information from Patients or Patient Guarantors

(1) General.

(a) 114.6 CMR 7.06 specifies the criteria that a hospital's Credit and Collection Policy must meet regarding the acquisition and verification of financial information from the patient and/or the patient guarantor in order to assess the ability of the patient or the patient guarantor to pay for hospital services.

7.06: continued

(b) The Credit and Collection Policy shall specify the procedures for obtaining patient financial information; the procedures for obtaining verification of any existing foreign health insurance coverage, including foreign governmental health care coverage; the procedures for obtaining verification of any motor vehicle liability policy; the procedures for verifying patient supplied information; and the projected completion time for the verification activities.

(2) Minimum Requirements for Patient Supplied Information. The patient supplied information shall include, but shall not be limited to, the patient's name and address, the guarantor's (if any) name and address, the source of any available payment and the amount of such payment.

(3) Inpatient Services.

(a) Non-Emergency Admissions. The hospital shall make reasonable efforts, prior to the date of the patient admission, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(b) Emergency Admission. The hospital shall make reasonable efforts, after the patient is admitted and as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(c) Requirements for Obtaining Additional Information During the Patient's Hospital Stay.

1. The hospital shall make reasonable efforts to contact the relatives, friends and guarantor and the patient for additional information while the patient is in the hospital.

2. The hospital shall identify the department that is responsible for obtaining the information from the patient, and explain the clinical approval process, if any, required in contacting the patient for additional information. If no clinical approval process is required prior to contacting patients, the Credit and Collection Policy must so specify.

(d) Requirements for Obtaining Information at the Time of the Patient's Discharge. If a hospital has not obtained sufficient patient financial information to assess the ability of the patient or the patient guarantor to pay for hospital services prior to the date of discharge, the hospital shall attempt to obtain the necessary information at the time of the patient's discharge.

(4) Outpatient Services.

(a) Non-Emergency Service. The hospital shall make reasonable efforts, prior to treatment, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(b) Emergency Service. The hospital shall make reasonable effort, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(5) Verification of Patient Supplied Information.

(a) Inpatient. The hospital shall make reasonable efforts to verify the patient supplied information prior to the patient discharge. However, the verification may occur at any time during the provision of services, or at the time of the patient discharge or during the collection process.

(b) Outpatient. The hospital shall make reasonable efforts to verify patient supplied information at the time the patient receives the services. The verification of patient supplied information may occur at the time the patient receives the services or during the collection process.

7.07: Criteria for Assisting Patients Who Have Limited Financial Resources

114.6 CMR 7.07 specifies the criteria that a hospital's Credit and Collection Policy must meet regarding the assistance of patients and/or patient guarantors with limited financial resources.

(1) Deposit Plan.

(a) The hospital shall not require pre-admission and/or pretreatment deposits for patients who require emergency services.

7.07: continued

(b) The hospital shall not require pre-admission and/or pretreatment deposits for patients with family income equal to or less than 200% of the Federal Poverty Income Guidelines.
(c) If hospitals require a pre-admission and/or pretreatment deposit for patients other than those described in 114.6 CMR 7.07(1)(a) and (b), the Credit and Collection Policy shall describe the method the hospital uses for establishing the amount of the deposit. and the document(s) required to verify the patient supplied information.

(2) Payment Plan.
(a) The hospital shall not require any payment plan for patients who are fully exempt from collection action pursuant to 114.6 CMR 7.08.
(b) A hospital's Credit and Collection Policy shall specify the hospital's policy regarding payment plans, including the methods for establishing patient liability, the information required from patients to establish payment ability, and the procedures used and the document(s) required to verify the patient supplied information.

(3) Deferred or Rejected Admissions.
(a) A hospital shall not defer or reject admission of patients who are recipients of governmental benefits under M.G.L. c. 117A *et seq.* (EAEDC) solely due to financial considerations.
(b) If a hospital wishes to defer or reject admission of other patients solely due to financial considerations, its Credit and Collection Policy shall specify the policies and procedures used for such decisions. In all instances, the reasons for deferral or rejection, and the clinical approval or acknowledgment of such deferral or rejection shall be documented.

7.08: Criteria for Identification of Populations not Requiring Collection Action

114.6 CMR 7.08 specifies the criteria for identifying those populations which shall not be subject to collection action as defined pursuant to 114.6 CMR 7.02. by setting a minimum free care eligibility standard. 114.6 CMR 7.08 also governs the criteria the Credit and Collection Policy must meet regarding the determination of patients exempt from collection action.

(1) General Requirements.
(a) All free care provided shall be accompanied by an application for free care signed by the patient, relative or legal guardian. Each application for free care must state, in part, the following:--"I authorize you to release any information acquired in the course of my examination or treatment to the Division of Health Care Finance and Policy or its designee."
(b) There shall be no residency requirements for patients who are residents of the Commonwealth of Massachusetts. If a hospital does not have such requirements for out of state patients the Credit and Collection Policy must so specify.
(c) The hospital or its agent shall not seek legal execution against the personal residence or automobile of patients or guarantors with family income in excess of 200% of the Federal Poverty Income Guidelines, without the express approval of the hospital's Board of Trustees on an individual case by case basis.
(d) The hospital shall not bill patients who are recipients of governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, certain participants of the Children's Medical Security Plan, as administered by the Department of Public Health, or the participants in the Department of Public Health's Healthy Start program or of the Department's Center Care program. The Department of Public Health (DPH) may issue periodic notices to the hospitals regarding billing of the participants in the Children's Medical Security Plan. However, the hospital may initiate billing for a patient who alleges that he or she is a participant in any of the programs listed in 114.6 CMR 7.08(1)(d), but fails to provide proof of such participation. Upon receipt of a satisfactory proof that a patient is a participant in any of the above listed programs, the hospital shall cease its collection activities.
(e) A patient who applies for free hospital services must receive a written notice of the hospital's decision within a month of completion of a written application and submission of the required information.

7.08: continued

(f) Once a hospital determines a patient to be eligible for free care hospital services the hospital may determine the patient to be eligible for such services for six months from the date of the initial determination.

(g) A hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age for persons beyond the age of majority, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or eligibility for free care.

(h) Any patient who is determined eligible for partial free care under 114.6 CMR 7.08(2)(c) and has a patient balance of $500 or more shall be offered in writing a payment plan of at least two years. A hospital may initiate any collection actions allowed under its Credit and Collection Policy for overdue payments, and may write-off overdue amounts as bad debt consistent with its Credit and Collection Policy. Nothing in 114.6 CMR 7.00 shall prohibit hospitals from assessing interest under such payment plans.

(2) Standards for Exemption of Patients from Collection Action.

(a) Recipients of governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, certain participants of the DET's Children's Medical Security Plan, or the participants in the Department of Public Health's Healthy Start program or of the Department's Center Care program shall be exempt from collection action. The Department shall issue periodic notices to the hospitals regarding collection actions affecting the participants in the Children's Medical Security Plan.

(b) If a hospital provides inpatient or outpatient services to a person whose family income is equal to or less than 200% of the Federal Poverty Income Guidelines, such person shall be exempt from collection action.

(c) If a hospital provides inpatient or outpatient services to a person whose family income is between 200% and 400% of the Federal Poverty Income Guidelines, such person shall be exempt from collection action for the portion of his/her hospital bill that exceeds 40% of the amount by which the patient's family income exceeds 200% of the Federal Poverty Income Guidelines for the patient's family size.

(d) If a hospital provides inpatient or outpatient services to a person whose family income is greater than or equal to 200% of the Federal Poverty Income Guidelines, the hospital shall exempt such person from collection actions with respect to all or part of the amount billed to the patient if the patient or guarantor is deemed to be financially unable to pay for the patient's hospital care due to medical hardship as determined pursuant to 114.6 CMR 7.08(3).

(3) Requirements Regarding Determination of Income, Family, Size and Medical Hardship.

(a) A hospital's Credit and Collection Policy shall specify the criteria and procedures that the hospital uses to determine whether a person shall be exempt from collection action under 114.6 CMR 7.08(2) for all or part of the bill. The Credit and Collection Policy shall distinguish, where relevant, between free care provided pursuant to 114.6 CMR 7.08(2)(a) through (c) and medical hardship provided pursuant to 114.6 CMR 7.08(2)(d). At a minimum, the Credit and Collection Policy shall:

1. Specify any forms or applications used to determine free care or medical hardship under 114.6 CMR 7.08(2);
2. Describe the procedures to be used in making the determinations required under 114.6 CMR 7.08(2), including any sliding scales used to measure the relationships between income, health care and insurance costs, and length of payment schedule; and
3. State who in the hospital is responsible for making decisions regarding eligibility for free care or medical hardship under 114.6 CMR 7.08(2)(d).

(b) When specifying the criteria and procedures that a hospital uses to determine medical hardship pursuant to 114.6 CMR 7.08(2)(d), the hospital's Credit and Collection Policy must, at a minimum, address whether it considers the following factors, and if so how:

1. The amount of the patient's family income -- adjusted for extraordinary expenses (such as high child care or parent costs) -- relative to the amount of his or her health care expenses and health insurance premium costs;
2. The existence and availability of family assets;

7.08: continued

3. The patient's future income earning capacity, especially where the patient's ability to work in the future may be limited as a result of illness; and
4. The patient's ability to make payments over an extended period of time.

7.09: Criteria for Notification of the Availability of Free Care to Patients

114.6 CMR 7.09 specifies the criteria that hospitals must meet regarding notification of the availability of free care and/or public assistance programs to patients. Hospitals shall employ the following procedures to notify patients of the availability of free care and to assist patients for possible eligibility for public assistance programs.

(1) Notification.

(a) Posting. The hospital shall post signs, in the inpatient, outpatient and emergency admissions/registration areas and in business office areas that are customarily used by patients, that conspicuously inform patients of the availability of free care and where to apply for such care. Such signs shall be in large print.

(b) Individual Notice. A hospital shall provide individual notice of availability of free care where a hospital has been given an indication that a patient will incur charges, exclusive of personal convenience items or services, that may not be paid in full by third party coverage. The individual notice shall specify the income and resource criteria the hospital uses in order to determine patient eligibility for free care, and the time it takes the hospital to make such a determination and include also information where patients can apply for free care. A copy of such notice must be included in the hospital's Credit and Collection Policy.

(c) A hospital shall include a notice of free care as described in 114.6 CMR 7.09(1)(b) in its initial bill. In all other written collection action the hospital shall include a brief message of the availability of free care and other types of assistance and what telephone numbers to call for more information.

(d) All signs and notices specified in 114.6 CMR 7.09(a), (b) and (c) shall be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the hospital's service area.

(2) Assistance. The hospital shall advise and assist patients concerning the patient's possible eligibility for public assistance programs. The policy and procedures for advising such patients shall include, at a minimum, the provision to patients of information concerning the availability of Medical Assistance Programs and the distribution of brochures for public assistance programs and the local legal services, if such brochures are made available to the hospital by Medicaid and the local legal services agency.

7.10: Documentation and Audit: Free Care Accounts

(1) Each hospital shall maintain auditable records of its activities made in compliance with the criteria and requirements of 114.6 CMR 7.00. The hospital shall document free care write-offs as reported on the RSC-403, DHCFP Form UC-92, DHCFP Form UC-93 or any successor form, or any other report that has been filed with the Division. . Each hospital's free care write-offs, shall be accompanied, at a minimum, by documentation of all efforts made by the hospital to determine free care eligibility.

(2) Documentation for free care accounts to verify family income, may cover a period from one to six months. Acceptable forms of documentation may include, but are not limited to, the following:

(a) a written, notarized, signed statement from the patient's employer;
(b) W-2 forms;
(c) pay check stubs;
(d) copies of payment checks;
(e) tax returns;
(f) bank statements;
(g) accounting records;
(h) benefit award letters;

7.10: continued

(i) social security benefit statements;
(j) retirement refund documents;
(k) court payment records; and
(l) broker statements.

A detailed description of a hospital's income information documentation process should appear in its Credit and Collection Policy.

(3) Income Documentation for Patients Without Resources. Should a patient report that there is no current source of family income and that no prior income information is available, a sworn, signed free care application and a brief statement describing how the patient is being supported may be considered sufficient documentation for audit. A detailed description of documentation requirements for patients without financial resources should appear in a hospital's Credit and Collection Policy. The hospital official responsible for determining eligibility under 114.6 CMR 7.10(3) must attempt to verify whether a free care applicant is currently receiving medical assistance from other governmental sources. In addition, the hospital official should inform the applicant that medical assistance through other governmental sources may be available.

(4) If a hospital fails to meet the requirements of 114.6 CMR 7.00, the Division may adjust the hospital's payments from the uncompensated care pool.

(5) The Division's audit procedures regarding free care accounts and the Division's schedule of audit adjustments regarding deficiencies in documentation shall be detailed in a separate administrative information bulletin issued pursuant to 114.6 CMR 7.12. The audit adjustments will reflect the degree of non-compliance with the Division's criteria for documentation of free care accounts.

7.11: Utilization Review

(1) In order to encourage maximum efficiency and appropriateness in the utilization of acute hospital services there shall be an utilization review for hospital admissions and continued acute hospital stays.

(2) The utilization review may be conducted by the Division or its designee.

(3) Nothing set forth in 114.6 CMR 7.11 shall be construed as affecting the calculations of payments to and from the pool as otherwise provided for in 114.6 CMR 7.04.

(4) Utilization review shall be conducted for those hospital admissions and continued acute hospital stays which are included in the calculation of the gross liability of a hospital from the uncompensated care pool. An utilization review shall not be conducted in those instances where another third party payer has conducted an utilization review.

(5) Utilization review shall be administered and conducted as set forth in the "Provider Reference Guide" which is incorporated herein by reference. All terms and conditions set forth in the "Provider Reference Guide" shall have the same force and effect as if fully set forth herein. All changes or amendments to the "Provider Reference Guide" shall be governed by the same procedural requirements as are 114.6 CMR. The effective date of 114.6 CMR 7.00 set forth in 114.6 CMR 7.01(1)(c)5. shall be construed consistently with and effectuating the dates set forth in the "Provider Reference Guide."

(6) Upon exhaustion of appeal of a review determination described in the "Provider Reference Guide" a hospital may seek an administrative review by the Division. The procedure of such administrative review by the Division shall be governed by 114.6 CMR 7.05(2) and (3). Such procedure shall be adopted, as appropriate to the unique requirements of the utilization review program.